STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375276	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Nursing Center	113 East Jones Chouteau, OK 74337

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facility failed to ensure care plans were updated quarterly for 5 (#4, 28, 1, 37, and #26) of 12 sampled residents whose care plans were reviewed.The administrator identified 34 residents who resided at the facility. Findings: 1.A Care Planning-Interdisciplinary Team policy, revised 09/2013, read in part, Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.The interdisciplinary team must review and update the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment. A care plan for Resident #4 showed it was last reviewed/revised on 01/31/25. A quarterly assessment, dated 01/16/26, showed Resident #4 had a BIMS score of 15, which indicated the resident was cognitively intact for daily decision making, and had diagnoses which included schizophrenia. On 03/16/26 at 1:05 p.m., the DON stated they were responsible to oversee the MDS coordinator to ensure care plans had been reviewed/revised quarterly and as needed. The DON stated the MDS coordinator was on vacation. They stated they did not know why the care plan had not been revised. 2. A physician order, dated 08/07/25, showed Resident #28 was admitted to hospice services for senile degeneration of the brain. A care plan showed it was last reviewed/revised on 01/31/25 and did not show a concern regarding hospice services. A quarterly assessment, dated 02/10/26, showed Resident #28 had a BIMS score of four, which indicated the resident was severely impaired in cognition for daily decision making, and a had chronic disease or condition that may result in a life expectancy of less than six months. On 03/16/26 at 1:07 p.m., the DON stated Resident #28 had received hospice services for less than one year. The DON stated they did not know why the care plan for Resident #28 had not been reviewed/revised since 01/31/25 to include hospice services. 3. A care plan for Resident #1 showed it was last reviewed/revised on 10/14/25. The care plan did (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not show a concern regarding nutrition. A dietician note, dated 10/10/25, showed Resident #1 had poor meal intake, a weight loss of 9.5% in six months, received a supplement, and the dietician would consult with the physician to determine if the resident was a candidate for an appetite stimulant. A dietician note, dated 12/10/25, showed Resident #1 had a weight loss of 5% in 1 month, to offer high calorie snacks twice daily, and periactin (an antihistimine medication used for appetite). A quarterly assessment, dated 01/11/26, showed Resident #1 had a BIMS score of nine which indicated the resident was moderately impaired in cognition for daily decision making, and had experienced a weight loss. On 03/16/26 at 1:49 p.m., the DON reviewed the care plan for Resident #1 and stated they did not know why the care plan had not been revised to reflect the resident's current status. They stated the care plan should have been revised to exclude fluid restriction that was currently reflected on the care plan and include nutrition/weight loss and the interventions they had in place. They stated they did not know why the care plan had not been updated. 4. An annual assessment, dated 10/23/25, showed Resident #37 had a BIMS of 15 and was cognitively intact for daily decision making. The assessment showed diagnoses which included emphysema and COPD. A care plan for Resident #37, reviewed/revised on 01/31/25 did not show a concern for hospice services. A physician's order, dated 03/09/26, showed Resident #37 was admitted to Hospice services with a diagnosis of COPD. On 03/16/26 at 1:23 p.m., the DON stated care plans were to be updated quarterly. 5. A care plan for Resident #26 showed it was last reviewed/revised on 02/24/25. A re-admission assessment, dated 05/14/25, showed Resident #26 had hospice services. The assessment showed Resident #26 had a prognosis of less than six months. A nurse progress note, dated 02/12/26, showed Resident #26 was observed by a CMA to put a cigarette in their pocket and the charge nurse had to obtain it. This was not included in the care plan. A nurse progress note, dated 03/03/26, showed Resident #26 had lit a cigarette in their room while wearing oxygen and it ignited. This was not included in the care plan. On 03/10/26 at 8:53 a.m., Resident #26 stated they burned themself while smoking and wearing oxygen. They stated the staff had treated the burn with Silvadene (ointment for burns) and it had helped. On 03/16/26 at 1:23 p.m., the DON stated care plans were to be updated quarterly. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/16/26 at 1:49 p.m., the DON stated they had reviewed the care plan for Resident #26. They stated care plans had not been reviewed/revised quarterly and as needed.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. On 03/11/26, an Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to provide supervision to prevent accident hazards related to smoking. On 03/02/26, Resident #26 was smoking in their room while wearing oxygen. The oxygen combusted which caused a facial burn, singed beard, and mustache hair. On 03/11/26 at 2:56 p.m., the Oklahoma State Department of Health verified the existence of an IJ situation. On 03/11/26 at 3:05 p.m., the administrator was notified of the IJ situation. An IJ template was provided to the administrator. On 03/12/26 at 10:47 a.m., an acceptable POR (plan of removal) was received. The POR read in part, Plan of Removal for lJ Amended 3/12/2026 at 0950 [9:50 a.m.]1. Notify Medical Director2. Notify resident # 26 hospice provider of lJ and coordination of care3. New Smoking Assessment for all smokers4. Review/revise smoking policy with resident and resident council with agreement and approval for revision of checking for any smoking material at the end of each smoke break. Update smoking policy to include observation of smoking residents to distinguish and dispose of smoking material ie: cig butts and return lighter at end of smoking times. With a check list to ensure each resident has complied. Staff supervising smoke break(s) will keep the smoking materials container in their passion[sic], with only one lighter available, and will give each resident only one cigarette at a time. All smoking materials brought in by friends/family are to be checked in at nurse's station.5. Post reviewed/revised smoking policy with resident council approval at nurses' station, by exit leading to smoking area.6. Have smoking residents sign revised smoking policy for acknowledging policy7. Administrator to In-Service Staff on revised smoking policy8. Regional supervisor to In-Service Administrator/DON on ODHS [sic] form 283 and completing with adequate supervision of residents and follow-up for accident and incidents related to smoking and charting for interventions and follow up care.9. Up-date care plan for resident # 26.10. Review all smoking residents care plan and revise as needed for adequate supervision/intervention for possible accidents/injury if occurrence happens.11. Move resident # 26 to room closer to nurse's station.12. Educate resident # 26 on hazards of smoking in room and the potential to harm self and other resident due to combustion with oxygen and possible injuries and sign education sheet and upload to resident EHR under resident documents.13. All ODHS [sic] for 283 will be sent to a Regional Supervisor for review for completeness and adequate intervention to prevent reoccurrence and follow-up,14. QAPI for lJ started and monitored for the above intervention for removal of lJ with monitoring implementation. The IJ was lifted, effective 03/12/26 at 10:15 a.m., when all components of the POR were verified. Observation of the room change for Resident #26 was made. Observation of placement of new smoking policy was made to ensure posted in listed areas. Care plans and assessments of smokers were reviewed to ensure updates were completed. The smoking policy was reviewed to ensure it had been updated. Interviews with residents who smoke were conducted to ensure education had been provided. Multiple staff from all shifts were interviewed to verify in-service was completed. The deficient practice remained at an isolated level with actual harm. Based on observation, record review, and interview, the facility failed to provide supervision to prevent accident hazards for 1 (#26) who smoked while wearing oxygen which resulted in facial burns, of 5 sampled residents reviewed who smoked. Regional Nurse #2 identified 5 residents in the facility who smoked. Findings: 1. On 03/10/26 at 8:53 a.m., Resident #26 was observed in the dining room with singed mustache hair above their lip and a wound approximately one inch wide by two inches long to the left of their upper lip. An undated, Smoking policy, read in part, Residents will not be allowed to have cigarettes or paraphernalia's [sic] such as: matches or lighters in their possession or in their rooms. These items (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	will be kept secured at the nurses' station and will be distributed at designated smoking times if applicable.No smoking is permitted in resident rooms or hallways. A care plan, reviewed/revised 02/24/25, showed Resident #26 had a concern for decreased oxygen levels due to a diagnosis of COPD and smoking. The interventions showed to perform smoking assessments quarterly according to facility policy, monitor when smoking to assure resident's safety, and provide smoking policy and rules regarding cigarette and lighter being kept at the desk. An admission assessment, dated 05/14/25, showed Resident #26 had a BIMS of 15, which indicated they were cognitively intact and smoked. A Smoking Assessment, dated 11/12/25, showed Resident #26 had demonstrated ability to safely smoke cigarettes with minimal supervision. A Smoking Assessment, dated 02/12/26, showed Resident #26 was observed to hide a cigarette in their pocket to smoke later. The assessment showed Resident #26 had demonstrated ability to safely smoke cigarettes with minimal supervision. A nurse progress note, dated 02/12/26, showed Resident #26 was observed by the CMA to put a cigarette in their jacket pocket to smoke later. The staff obtained the cigarette and educated the resident on the dangers of smoking while wearing oxygen. A quarterly assessment, dated 02/12/26, showed Resident #26 had a BIMS of 15 and was cognitively intact for daily decision making. The assessment showed diagnoses which included lung cancer of the right lower lobe, anxiety, depression, paranoid schizophrenia, COPD, and respiratory failure. A nurse progress note, dated 03/03/26, showed Resident #26 had smoked in their room the night before while wearing oxygen and the resident's face had been burned. On 03/10/26 at 8:53 a.m., Resident #26 stated they burned themself while smoking and wearing oxygen. They stated the staff have treated the burn with Silvadene (wound ointment) and it had helped. On 03/11/26 at 12:28 p.m., CNA #1 stated residents had set times for smoking, and they were posted all over the building. They stated residents required staff with them at all times while smoking. CNA #1 stated residents were not allowed to keep cigarettes and lighters on them and when staff entered their rooms, they were to use sight and smell to determine if a resident had been smoking in their room. They stated they were to report to the nurse if there were signs of smoking. On 03/11/26 at 12:34 p.m., CMA #1 stated residents could smoke in designated areas and must be evaluated for safe smoking. They stated the smoking hours were posted. CMA #1 stated cigarette butts must be put in the receptacle, and someone must supervise residents while they smoked. CMA #1 stated they had observed cigarette ash around the toilet of Resident #26 in the past and thought they had reported it to a charge nurse. On 03/11/26 at 12:48 p.m., the DON stated residents were able to sign themselves out and go smoke out front at the end of the sidewalk. They stated in the past housekeeping had found ashes on the toilet seat of Resident #26. The DON stated since the incident on 03/02/26, the facility did not allow residents to have smoking materials in their possession; staff provided direct supervision and lit their (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	cigarettes for them. They stated staff supervised residents while they smoked. The DON stated they completed smoking assessments quarterly. The DON stated they could not be sure they obtained all the lighters from Resident #26 and stated, I can't legally go through their stuff. On 03/11/26 at 1:03 p.m., the administrator stated residents had regular smoke times and the CMA would hold the lighter and light the resident's cigarettes. The administrator stated in the past housekeeping had reported ashes on the toilet seat of Resident #26. They stated the last time this was reported was a couple months ago. They stated they asked Resident #26 if they had been smoking in their room and the resident stated they had smoked in their room but would not do it anymore. The administrator stated they had confiscated the smoking materials from Resident #26. The administrator stated on 03/03/26, the day after the incident, the maintenance director had found a lighter under the bed of Resident #26. The administrator stated it had been reported to them Resident #26 had been smoking in their room six times from 01/02/26 to 03/03/26. They stated there was no guarantee residents did not have lighters or cigarettes in their room.